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IN THE
Supreme Court of the United States
OCTOBER TERM, 1987

OTIS R. BOWEN, Secretary of Health and Human Services,
Petitioner

v.

KENNETH KIZER, Director of the California Department of Health Services, *et al.*,
Respondents

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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AMICI CURIAE BRIEF IN SUPPORT OF RESPONDENT OF MARYLAND, MINNESOTA, NEBRASKA, NORTH CAROLINA, NORTH DAKOTA, TENNESSEE, VERMONT, AND WASHINGTON

LACY H. THORNBURG
Attorney General of the
State of North Carolina
Department of Justice
P.O. Box 629
Raleigh, N.C. 27602-0629

HENRY T. ROSSER
Assistant Attorney General
Counsel of Record

(Names and addresses of additional Attorneys General are listed infra.)

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

W.J. MICHAEL CODY
Attorney General
State of Tennessee
Office of the Attorney General
450 James Robertson Parkway
Nashville, TN 37219-5025

NICHOLAS J. SPAETH
Attorney General
State of North Dakota
State Capitol
Bismarck, ND 58505

JEFFREY L. AMESTOY
Attorney General
State of Vermont
Pavilion Building
c/o State Office Building
State Street
Montpelier, VT 05602

HUBERT H. HUMPHREY III
Attorney General
State of Minnesota
Room 102
Capitol Building
St. Paul, MN 55155

J. JOSEPH CURRAN, JR.
Attorney General of Maryland
Munsey Building
Calvert and Fayette Streets
Baltimore, MD 21202

ROBERT M. SPIRE
Attorney General
State of Nebraska
Department of Justice
Lincoln, NE 68509

KEN EIKENBERRY
Attorney General
Office of the Attorney General
Temple of Justice
Olympia, WA 98504

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INTEREST OF THE AMICI CURIAE STATES

The interest of the *amici* States* arises from their responsibility for administering—through an appropriate state agency—their Medicaid state plan and program. Each of the *amici* States, as required by federal statute, provides Medicaid benefits to the "categorically needy"

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* The *amici* States file this *Amici Curiae* Brief pursuant to Supreme Court Rule 36.4 which provides for filing such a brief without consent of the parties.

i.e., AFDC recipients, impoverished pregnant women and young children, and elderly, blind, or disabled SSI recipients. 42 U.S.C. § 1396a(a)(10)(A)(i). *See Atkins v. Rivera*, 106 S. Ct. 2456, 2458 (1986).[1]

Each of the *amici* States also has opted to provide Medicaid coverage to the "medically needy," that is, those who meet the non-financial eligibility requirements for cash assistance but whose income or resources are too high to allow them to qualify for welfare benefits. 42 U.S.C. § 1396a(a)(10)(C). *See Schweiker v. Hogan*, 457 U.S. 569, 581-582 (1982) and *Atkins*, 106 S. Ct. at 2459. These individuals qualify for Medicaid by virtue of having income below the state's established medically needy income level (MNIL) or by incurring medical expenses, thereby "spending down" their "excess" income so as to put them within their state's MNIL. *Atkins*, at 106 S. Ct. 2459.

Amicus State of North Carolina presently provides Medicaid services to approximately 85,000 medically needy recipients at an annual cost of approximately $350 million, of which 69.18 percent is reimbursable to the State from the Petitioner. The *amicus* State of Tennessee presently provides Medicaid services to approximately 27,000 medically needy recipients at an annual estimated cost (for the year July 1, 1986 through June 30, 1987) of approximately $60 million, of which 70.26 percent is reimbursable from the Petitioner. About 13,419 individuals receive medically needy benefits in *amicus* State of North Dakota, at an annual cost in 1986 of almost $70 million. The remaining *amici* states on this brief have

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[1] *Amici* North Carolina, North Dakota, Minnesota, and Nebraska participate in the Medicaid program under the so-called "209(b) option" under which receipt of SSI benefits does not make an elderly, blind or disabled individual automatically eligible for Medicaid. 42 U.S.C. § 1396a(f). *See Schweiker v. Gray Panthers*, 453 U.S. 34 (1981).

comparable financial and administrative commitments to medically needy programs.

Amici have a substantial interest in this Court's sustaining that portion of the decision below regarding the application of the DEFRA moratorium.[2] 781 F.2d 1421, 1429-30 (9th Cir. 1986). Some have attempted to adopt standards for the medically needy which are less restrictive than those used in cash assistance programs, and all have an interest in having the administrative flexibility to do so in the future. In fact, like the Respondent in this case, the *amicus* State of Nebraska has sought to raise its medically needy income level (MNIL) for an adult couple to 133⅓ percent of the AFDC grant level for a family of three, and has been denied approval of such action by Petitioner. *See* Appendix A to this brief at A-1 to A-8.

Amici maintain that the moratorium was intended to provide them, and all other state agencies administering the Medicaid program, with the option to employ more administratively feasible methodologies and standards in their medically needy programs. Petitioner, on the other hand, has taken an extremely restrictive view of the moratorium. In numerous instances Petitioner has refused to approve state plans containing more flexible rules for the medically needy population. Since the moratorium would protect them from loss of federal dollars, *amici* have a substantial interest in insuring that this Court's construction of the moratorium furthers the intent of Congress that States be allowed to establish less restrictive standards and methodologies in their medically needy programs.

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[2] *Amici* do not address or take a position in this brief on the Circuit Court's holding that ROM § 2572-D had the "force and effect of law" and therefore was binding on Petitioner.

SUMMARY OF ARGUMENT

1. The DEFRA moratorium provides state agencies with the option to implement less restrictive and more administratively feasible standards and methodologies for their medically needy population. The moratorium is of limited duration, during which time Congress is to study, assess and ultimately legislate an appropriate approach to the application of cash assistance rules in the medically needy program.

2. The moratorium provides States with necessary flexibility since many cash assistance program rules are administratively cumbersome and ill-suited to the medically needy program.

3. Petitioner's refusal to apply the moratorium in this case is reflective of his overly restrictive view of this statutory provision. Since its passage, Petitioner has interpreted the moratorium provision so narrowly as to nullify Congressional intent.

ARGUMENT

I. CONGRESS PASSED THE DEFRA MORATORIUM AS A TEMPORARY MEASURE DURING WHICH TIME STATES COULD APPLY LESS RESTRICTIVE STANDARDS AND METHODOLOGIES IN THEIR MEDICALLY NEEDY PROGRAMS.

It is necessary to review briefly the legislative history of the Medicaid medically needy program to appreciate the context in which the moratorium was passed in 1984, and thus to gauge accurately its purpose. Prior to 1981, § 1902(a)(10)(C) of the Social Security Act required that eligibility standards for the medically needy be "comparable" to those used for the categorically needy. *See Atkins v. Rivera*, 106 S.Ct. 2456, 2462 (1986). Petitioner and numerous courts understood this language to mean that states were prohibited from using medically

needy criteria which were more restrictive than those used in the cash assistance programs, but were permitted to use more liberal standards. *See, e.g.* 42 C.F.R. §§ 435.401(c)[3], 435.812, 435.840 (1979). *See generally, Caldwell v. Blum*, 621 F.2d 491, 495 (2d Cir. 1980), *cert. den.*, 452 U.S. 909 (1981); *Calkins v. Blum*, 511 F.Supp. 1073, 1091 (N.D.N.Y 1981), *aff'd*, 675 F2d 44 (2d Cir. 1982).

In 1981, through the Omnibus Budget Reconciliation Act (OBRA), Congress amended § (a)(10)(C) to give states additional flexibility in designing their medically needy programs. Pub. L. 97-35, § 2171(a)(3), 95 Stat. 357, 807. During debate, the managers of the bill made clear that Congress did not intend to permit any change in existing comparability rules. 127 Cong. Rec. 18,957 (middle column) (July 31, 1981) (Rep. Dingell); *Id.* at 18,948 (middle column) (Rep. Waxman). *See generally DeJesus v. Perales*, 770 F.2d 316, 325 (2d Cir. 1985).

However, Petitioner interpreted OBRA erroneously by promulgating regulations allowing States to use income and resource criteria for medically needy more restrictive than those for the categorically needy. 46 Fed. Reg. 47,980 (1981). *See Atkins*, 106 S. Ct. at 2462-2463 (1986). Congress' response to Petitioner's OBRA-inspired regulations has been duly noted by this Court:

> Congress disagreed with the Secretary's interpretation. *See, e.g.*, 127 Cong. Rec. H7052 (Oct. 6, 1981) (remarks of Rep. Waxman). This disagreement led to the enactment of the "same methodology" proviso, as part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), § 137(a)(8), 96 Stat. 378. The House Report explained that TEFRA "makes clear that the Department [of Health and Human Services] had no authority to alter the rules that applied before September 30, 1981, with respect to

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[3] This regulation has not been repealed or amended.

> medically needy income levels, medically needy resource standards, and the methodology for treating medically needy income and resources." H.R. Rep. No. 97-757, pt. 1, p. 13 (1982). The House Report further explained that TEFRA reaffirmed "the financial requirements previously in effect for the medically needy." *Ibid.*

Atkins, 106 S. Ct. at 2463.

The "same methodology" proviso enacted in TEFRA added to the Medicaid statute's existing language the requirement that a state plan include a description of:

> the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals . . . and which shall be the same methodology which would be employed under the appropriate State plan . . . to which such group is most closely categorically related in the case of other groups. . . .

Pub. L. No. 97-248, § 137(a)(8)(B), 96 Stat. 324, 378 (1982), *codified at* 42 U.S.C. § 1396a(a)(10)(C)(i)(III).

Unfortunately, Petitioner again misinterpreted Congressional intent behind TEFRA's legislative change. In communications with the state agencies, Petitioner's Health Care Financing Administration (HCFA) insisted that these agencies apply SSI or AFDC income and resource rules to the letter in determining medically needy eligibility.[4] Petitioner required adherence to AFDC and SSI rules regardless of how inappropriate or administratively cumbersome they might be when applied to the medically needy program.

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[4] See, DEFRA Conference Report language, quoted *infra*, p. 8, and "first day of the month" rule discussion, *infra*, pp. 11-13.

Congress' passage of the moratorium in the Deficit Reduction Act of 1984 (DEFRA), therefore, was not a lightly-considered response to a minor administrative flaw in Petitioner's operation of the Medicaid program. Rather, the moratorium was an attempt by a perturbed and somewhat frustrated legislative body to put a temporary halt to Petitioner's misinterpretation of the TEFRA amendment so that it might consider and pass a longer-term constructive response to the problem. Understandably, Congress this time stated its intent in the most unambiguous and mandatory terms:

> (c) (1) The Secretary of Health and Human Services *shall not take any* compliance, disallowance, penalty, or other regulatory action against a State during the moratorium period described in paragraph (2) by reason of such State's plan under Title XIX of the Social Security Act being determined to be in violation of section 1902(a) (10) (C) (i) (III) of such Act *on account of such plan's having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section.*
>
> (2 The moratorium period is the period beginning on the date of the enactment of this Act and *ending 18 months after the date on which the Secretary submits the report required under paragraph (3).*
>
> (3) *The Secretary shall report to the Congress within 12 months* after the date of the enactment of this Act *with respect to the appropriateness, and impact on States and recipients of medical assistance of applying standards and methodologies utilized in cash assistance programs to those recipients of medical assistance who do not receive cash assistance, and any recommendations for changes in such requirements.*

§ 2373(c) (1)-(3) of Pub. L. 98-369, 98th Cong., 2d Sess. (1984). (emphasis added)

Lest there be misinterpretation by Petitioner once again, Congress provided a detailed explanation in its Conference Report as to the intent and reach of the moratorium in DEFRA:

> The conference agreement directs the Secretary not to take any compliance, disallowance, penalty or other regulatory action against a State because a State, in determining eligibility for noncash Medicaid recipients, is using an income or resource standard or methodology that is less restrictive than the applicable cash assistance standard or methodology.

H.R. Rep. No. 861, 98th Cong. 2d Sess. 1366 (1984), *reprinted* at 1984 U.S. Code Cong. & Ad. News 2054.

The Conference Report reviewed the legislative developments (described above) leading to the moratorium. It then provided specific eligibility determination examples to which the moratorium was intended to apply:

> [I]*t is the understanding of the conferees that the Department has implemented* [the TEFRA provision] *in an overly literal fashion, without taking into account the intent of the TEFRA clarification.*
>
> *For example*, the Department is treating certain income and resource rules as "methodology" that must strictly follow SSI or AFDC rules, even though all States with medically needy programs have traditionally been permitted to use less restrictive rules in certain areas. Thus, the Department has taken the position that aged, blind, and disabled medically needy applicants who enter nursing homes and who have marginally excess resources on the first day of the month can not attain Medicaid eligibility during the month, even after their resources are sufficiently depleted by medical costs, because SSI rules only allow eligibility from the first of the month. The Department has also indicated that it may impose quality control sanctions against the States that are using eligibility procedures that were allowed before OBRA and which make sense in the context of the

> medically needy program but which happen to be *less restrictive* than the relevant cash assistance procedures. Similarly, the Department has taken the position that the "single standard" requirement of the TEFRA amendment prohibits States from establishing less restrictive medically needy income levels for single adults and couples because this would result in differences in medically needy income levels among groups of the same family size depending on the relative numbers of adults and children.
>
> *The Department's overly restrictive interpretation of section 137(a)(8) of TEFRA has posed grave administrative problems for the States and threatens to cause great hardship for applicants and beneficiaries.* It is also clear to the conferees that *the strict application of the cash assistance rules to the medically needy and other noncash groups produces unintended, and in some cases, undesirable, consequences.* The conferees have therefore decided to impose a moratorium on the Department's implementation of the TEFRA amendment until the Congress has an opportunity to study and legislate on the matter.

Id. at 1367, 1984 U.S. Code Cong. & Ad. News at 2055. (emphasis added)

Finally, the Conference Report reiterated in unambiguous language the protection afforded state agencies via the moratorium:

> *The conferees intended that, during the moratorium, the Secretary not proceed with the imposition of any sanctions, or otherwise suggest to the States that they must use more restrictive cash assistance standards and methodologies* in their medically needy or other noncash recipient programs. States may use less restrictive standards and methodologies in their noncash programs, although they are still foreclosed from being more restrictive than the relevant cash assistance programs. *It is the expectation of the conferees that the States will be reasonable in establish-*

ing less restrictive variations in the cash assistance methodologies and standards.

Id. at 1368, 1984 U.S. Code Cong. & Ad. News at 2056. (emphasis added)

Thus, in passing the moratorium Congress was instructing Petitioner to halt the present literal interpretation of its TEFRA changes and to allow states flexibility in administering their medically needy programs. *See Atkins v. Rivera*, 106 S. Ct. at 2463 n. 10.

The moratorium prohibition on denying federal matching dollars to states with more flexible medically needy rules was entirely justifiable to Congress since it was to be in effect for a relatively short period of time. Petitioner was directed by Congress to furnish it with a report on the propriety of applying cash assistance rules in the medically needy program. Had Petitioner complied with the time requirements of the moratorium, a report on this issue would have been submitted to Congress by July 18, 1985, and the moratorium would have expired 18 months later, January 18, 1987. Given this limited period of time and given the ongoing misinterpretations of prior legislation by Petitioner, it is not at all difficult to understand Congress' broad mandate in the DEFRA moratorium.

II. THE MORATORIUM PROVIDES STATES WITH NECESSARY FLEXIBILITY SINCE MANY CASH ASSISTANCE PROGRAM RULES ARE ADMINISTRATIVELY CUMBERSOME AND ILL-SUITED TO THE MEDICALLY-NEEDY PROGRAM

Congress passed the DEFRA moratorium because it understood that Petitioner's erroneous interpretation of TEFRA's "same methodology" language was forcing State agencies to use cash assistance rules that simply do not make sense when applied to the medically needy program. In 1985, the American Public Welfare Association issued an interim report prepared by the State Medi-

caid Directors Association's Eligibility Technical Advisory Group, which corroborated Congress' concerns.[5] The report presented the results of a survey of the States.[6] In its Executive Summary, the report states:

> The overwhelming conclusions indicate that the direct link between Medicaid and the cash programs result in:
>
> —impoverishment
>
> —increased State and Federal costs
>
> —burdensome administrative practices

State Medicaid Directors Report at Executive Summary (opening page of interim report); App. at A-10.

The following brief review of several cash assistance eligibility practices and their application to the medically needy program, underlines Congress' wisdom in establishing the moratorium.

1. *SSI "First Day of the Month Rule"*

The Supplemental Security Income (SSI) program's "first day of the month" rule is a prime example of a cash assistance policy that plays havoc when applied to the medically needy program. The rule essentially provides that individuals whose resources exceed SSI standards as of the first day of the month must be considered ineligible for SSI cash benefits for the entire month. 20 C.F.R. 416.421(b) as provided at 51 Fed. Reg. 13,493

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[5] "State Medicaid Directors Report to Congress on Medicaid Eligibility Issues," prepared by the State Medicaid Director's Association of the American Public Welfare Association. [Hereinafter cited and referred to as "State Medicaid Directors Report"]. Relevant excerpts from the report are set out in the Appendix, A-9 to A-17.

[6] State Medicaid Directors Report at 7; App. at A-12. The report states that a total of 39 states responded to the Association's survey, either by completing questionnaires or by telephone response.

(April 21, 1986). The rule may not be unreasonable in the SSI program since clients with excess resources, even if slightly above SSI standards, could use these resources to meet basic maintenance needs of food, clothing and shelter during the month, and then qualify for SSI for the following month.[7] However, a Medicaid applicant or recipient in need of institutional care in a hospital or nursing home can easily incur several thousands of dollars worth of medical costs in a month.

Despite the fact that medical costs can quickly exceed the SSI resource level, the "first day of the month" rule prohibits Medicaid coverage even if the individual's resources at the beginning of the month only slightly exceed the SSI limit.[8] In the survey of states reported in the State Medicaid Directors Report, 76.9 percent of those responding indicated that the "first day of the month" rule was detrimental to the Medicaid client population, and 38.5 percent indicated that the policy was detrimental to state administration of the Medicaid program. State Medicaid Directors Report, *supra* at 7 and 12.[9]

In the DEFRA Conference Report, the "first day of the month" rule was itemized specifically by the conferees as a cash assistance program rule that states should not have to apply in their medically needy programs. *See*

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[7] In 1987 SSI eligibility resource limits are $1800 for an individual and $2700 for a couple. 42 U.S.C. § 1382(a)(3)(A).

[8] For example, an individual with income below the SSI eligibility standard but with $1,850 in liquid resources on the first day of the month—who suffers a medical crisis requiring $10,000 in hospitalization between the 1st and 15th of the month, and $1,500 worth of recooperative nursing home care the latter half of the month—would be ineligible for Medicaid assistance due to the "first day of the month" rule.

[9] App. A-12 and A-14. The report refers to the rule as the "12:01 AM Resource Policy" since exceeding the resource standard as of the first minute of the first day of the month renders the applicant ineligible for the month.

H.R. Rep. No. 861, *supra* at 1367. Despite the inequity of applying the policy in the Medicaid program, and despite the Conference Report language, Petitioner continues to disapprove state plan amendments that do not contain the "first day of the month" requirement.

2. *SSI "In Kind" Income Policies*

Under current SSI requirements, when an elderly, blind or disabled individual is living in the home of a person (such as his adult child) who is providing him with free shelter and food, such support is considered "in kind" income. For SSI eligibility purposes, such in kind income is valued at one-third of the SSI standard which amount is then reduced from the SSI federal benefit rate to determine the recipient's actual SSI grant.[10] 42 U.S.C. § 1382a(a)(2)(A); 20 C.F.R. §§ 416.1130 and .1131. Similarly, if an SSI applicant/recipient is receiving free room and/or board but is not living in the home of the individual providing such in kind support, the "presumed value" of the in-kind income, is deducted from the SSI benefit. 20 C.F.R. §§ 416.1140 and .1141.

These "in kind" income policies may make sense in the SSI program, but they cause inequitable results in the Medicaid program. If an individual's actual income plus his "in kind" income is greater than the SSI standard, he is denied a cash assistance grant. However, under Petitioner's interpretation of TEFRA's "single standard" language, to receive Medicaid the applicant will now be required to "spenddown" (incur medical expenses) his "excess" income to the State's medically needy income level, a standard often below the SSI level. Moreover, in a majority of states with medically needy programs the spenddown amount is calculated on a six-month basis,

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[10] Arguably, TEFRA's "same methodology" provision could allow attribution of one-third of the state's medically needy income level (MNIL), which in most states is lower than the SSI eligibility standard.

i.e., six times the monthly "excess." *See Atkins v. Rivera*, 106 S. Ct. 2456 (1986). Thus, an impoverished medically needy applicant may be faced with a substantial spend-down requirement based, partially, on a calculation of "in kind" income, i.e., income that the applicant cannot spend on medical care.

According to the State Medicaid Directors Report, 79.5 percent of the states responding to its survey agreed that the application of non-liquid in-kind income policies was detrimental to the client population. App. A-13 and A-15. In addition, 71.8 percent maintained that the in-kind income policy was cost detrimental to administration of the Medicaid program. App. A-13. The Report also noted:

> OBRA promulgated policies intended to encourage the utilization of long term home health care as an alternative to having the frail elderly institutionalized in a long term care facility (i.e., nursing home). Requiring states to consider the value of the in-kind income or the one-third reduction serves as a disincentive for families and friends willing to bring the frail elderly into their homes since in many instances the reduction decreases the elderly person's monthly cash by requiring them to incur medical expenses before becoming fully eligible for Medicaid. The cash SSI policy and the purposes and intent of the Medicaid program are clearly incompatible in these areas.[11]

3. *SSI and AFDC Proration Policies*

The State Medicaid Directors Report provides an additional example of cash assistance program rules that make little sense in the Medicaid program. In both the SSI and Aid to Families with Dependent Children (AFDC) programs, eligibility is established as of a specific day in the month. Both programs pro-rate the

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[11] App. A-11 to A-12.

initial cash grant to cover the days from the effective date of eligibility through the end of the month.[12] Again, these policies may not be unreasonable in the cash assistance programs, since an individual applying for cash assistance at some point in a month, presumably has managed without monetary assistance up to that date. However, the same rule being applied in the medically needy program can be devastating since application for Medicaid is often triggered by unexpected, already-incurred medical expenses.

The hypothetical example provided in the State Medicaid Directors Report illustrates the inequity of applying the date specific rule:

> Mr. and Mrs. H and their two children are just managing to make ends meet on his net unemployment insurance of $487 per month. One of the children is rushed to the hospital on June 3 for an emergency appendectomy. Realizing that they no longer have health insurance since Mr. H was laid off, they file for Medicaid on June 8 as soon as the child is out of the hospital. On June 15 they are determined eligible for Medicaid effective on that date. However, coverage is not available for the period from June 3 to June 8, since eligibility had not yet been established, and the H's are faced with a hospital bill of $3,000 which they have no means to pay.[13]

The Medicaid statute specifically requires states to provide retroactive Medicaid coverage for a period of not more than three months prior to the month of application if an individual would have been eligible for such coverage had he or she applied during the retroactive period.

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[12] See 20 C.F.R. § 416.420(b)(1) (SSI rule) and 45 C.F.R. § 206.10(a)(6) (AFDC rule). As pointed out earlier, however, SSI also prohibits eligibility in a month in which an individual's resources are in excess of the resource standard as of the first day of that month.

[13] Addendum A to State Medicaid Directors Report. App. A-16 to A-17.

42 U.S.C. § 1396a(a)(34). Thus in the hypothetical above, the H family may be eligible for Medicaid in March, April and May under the retroactive provision of the statute, but might not be eligible in the beginning of June because state agencies are imposing the "date specific eligibility policy" of the AFDC program. Not surprisingly, 66.7 percent of the 39 states responding to the State Medicaid Directors survey believed that requiring date specific eligibility was detrimental to the client's interests, and 77 percent felt that allowance for establishing eligibility as of the first day of the month of application had no administrative effect or was administratively easier for the state agency. *Id.*, at Addendum B. App. A-17.

4. *SSI's "Bona Fide Effort to Sell" Rule*

Petitioner's "bona fide effort to sell" rule is another graphic example of a cash assistance program policy that is counterproductive when applied to the Medicaid program. SSI rules for the treatment of resources provide that if a property right cannot be liquidated, the property will not be considered a resource of the applicant for eligibility purposes. 20 C.F.R. § 416.1201(a). In turn, Petitioner's Program Operation Manual System (POMS), an SSI policy manual, provides that when a "bona fide effort to sell is made to dispose of a resource and evidence shows there is not a current market for the resource, then the resource shall not be counted . . . ." POMS § 101330.330.

In June, 1985, HHS/HCFA sent out a memorandum describing a decent development in SSI policy affecting Medicaid eligibility. Memorandum 85-4 from Director, BERC to Regional Administrators, Region I-X, "Medicaid Eligibility-Status of SSI Resources Policy Relating to 'Bona Fide Effort to Sell'" (June 3, 1985). App. A-18. The memorandum stated that SSI resource policy, as reflected in a recent Social Security Ruling, does not allow

the "bona fide effort to sell" policy. It therefore concluded that Medicaid eligibility based on "bona fide effort to sell" does not exist.

While the effect of such an interpretation of the "bona fide effort to sell" rule on SSI recipients could be substantial,[14] i.e., loss of SSI cash assistance, the HCFA application of this new SSI methodology had far graver implications for Medicaid nursing home recipients who had been attempting to sell their homes. These elderly, infirm residents were put in the position of becoming ineligible for Medicaid because the homes they were attempting to sell could no longer be treated as exempt resources. Indeed, the policy is counterproductive even from the perspective of cutting program costs. Recipients were required to sell their homes at any price so as not to lose eligibility and thereby face eviction from their nursing home. A far more sensible approach would be for recipients to be allowed a reasonable period in which to sell their home, the proceeds from which could reimburse Petitioner and state agencies for Medicaid nursing home costs expended during the interim period. The "bona fide effort to sell" policy change is a clear example of where the DEFRA moratorium should allow state agencies to apply a more flexible methodology for their medically needy recipients.

5. *Households Containing AFDC- and SSI-Type Members*

Attempting to apply the appropriate AFDC or SSI cash assistance rule can be particularly burdensome for state agencies when the applicant household contains both AFDC- and SSI-type members. For example, a family unit can include a disabled mother, a non-disabled child,

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[14] *Amici*, in this brief, take no position on the accuracy or legality of the above-stated conclusion of the Petitioner as to the application of the "bona fide effort to sell" rule in the SSI or Medicaid programs.

and no father or alternatively, the family may consist of a disabled father, a non-disabled mother, and children. In such cases, the disabled family member is "linked" to the SSI program while the remaining family members are "linked" to the AFDC program. In addition, federal Medicaid regulations require a state agency to allow an individual who would be eligible for Medicaid under more than one category to have his eligibility determined under the category he or she selects (AFDC, SSI, medically needy). 42 C.F.R. § 435.404. Thus, persons who qualify as both SSI-linked and AFDC-linked medically needy must be provided a choice of category under which they wish to have their Medicaid eligibility and benefits computed. *See Calkins v. Blum*, 511 F.Supp. 1073, 1097 (N.D.-N.Y. 1981). The DEFRA moratorium clearly allows States flexibility in administering their medically needy programs by applying a single methodology to such "mixed" households, rather than having to apply different methodologies to different members of the family.

III. PETITIONER'S REFUSAL TO APPLY THE MORATORIUM IN THIS CASE IS REFLECTIVE OF HIS OVERLY RESTRICTIVE VIEW OF THIS STATUTORY PROVISION. SINCE ITS PASSAGE, PETITIONER HAS INTERPRETED THE MORATORIUM PROVISION SO NARROWLY AS TO NULLIFY CONGRESSIONAL INTENT.

In his brief, Petitioner maintains that the DEFRA moratorium does not apply in this action. Rather, Petitioner argues that the 133⅓ percent cap in § 1903(f) [42 U.S.C. § 1396b(f)] operates independently of the "single standard" provision in the medically needy section of the statute. 42 U.S.C. § 1396a(a)(10)(C)(i)(III). Brief for Appellant at 34-35. While *amici* will leave it to Respondent to address the specifics of this argument, it is important for this Court to view Petitioner's position from the perspective of how he has applied the moratorium since its passage. Despite numerous state pro-

posals to adopt standards or methodologies which the moratorium would appear to permit, Petitioner almost invariably rejects such amendments. In essence, Petitioner has rendered the moratorium a nullity, constantly refusing to allow state agencies flexibility in their medically needy programs.

Petitioner has justified this position by relying on a policy decision that the moratorium protects more liberal state medically needy methodologies only if they were "already in existing approved state plans as of the date of the enactment of the [DEFRA] (June 18, 1984)." [15] Of course, given HCFA's strict reading of TEFRA, it would not have approved any state plans with more liberal methodologies at least since TEFRA was enacted. There is no basis whatsoever in the moratorium provision or in the Conference Report to substantiate this restrictive and illogical reading of the moratorium's scope. Indeed, the Conference Report specifically indicates that Petitioner's reading of the statute is in error. The conferees state that they expect "the states *will* be reasonable in establishing less restrictive variations in the cash assistance methodologies and standards." H. Rep. 98-861, *supra*, at 1368. (emphasis added). Clearly, the conferees envisioned states exercising the moratorium's flexibility post-DEFRA.[16]

An example of how Petitioner has used this erroneous interpretation of the moratorium to nullify Congressional mandate can be found in his application of the previously-discussed "first day of the month" rule. *See, supra* at 11-13. In 1982, Petitioner's Health Care Financing Administration (HCFA) began informing States that Medicaid applicants whose resources exceed allowable

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[15] HCFA/HHS Medicaid Action Transmittal No. 85-1 (Jan. 1985), at 4. This transmittal can be found at A-20 to A-26.

[16] The Ninth Circuit, in its decision below, correctly rejected Petitioner's July 18, 1984 moratorium deadline. 781 F.2d at 1430.

state standards as of the first day of the month must be considered ineligible for Medicaid for the entire month.[17] This policy, according to Petitioner, reflected SSI policy at the time.[18] As noted previously, in the DEFRA Conference Report the "first day of the month" rule was itemized specifically by the conferees as one of the cash assistance program rules that states need not apply in their medically needy programs. *Supra* at 8. Nonetheless, despite the Conference Report language, Petitioner continues to disapprove state plan amendments that do not contain the "first day of the month" requirement, and looks to its self-imposed July 18, 1984 deadline as justification for such disapproval.

The absurdity of Petitioner's position can be seen in its dealings with the State of North Carolina. That State's plan amendment was rejected by Petitioner by letter dated October 25, 1985, which noted that the moratorium was not applicable since the more restrictive "first day of the month" rule was in the State's plan as of July 18, 1984 (date of DEFRA's enactment).[19] Petitioner took this position despite the fact that the State initially had *not* instituted the restrictive rule, and only did so in September 1983 because Petitioner specifically so required.[20] In other words, North Carolina had no "first

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[17] *See*, for example, Letter from James J. Pirkle, HCFA, Reg. IV to Barbara Matula, Director, Div. of Medical Assistance, North Carolina (3/28/83). This transmittal is found at App. A-27 to A-28.

[18] *Ibid.*

[19] Letter of Oct. 25, 1985 from HCFA's Acting Administrator, C. McClain Haddow to Phillip Kirk, Secretary of North Carolina Dept. of Human Resources. App. A-29 to A-30.

[20] Memorandum on Behalf of Petitioner in Reconsideration of Disapproval of North Carolina State Plan Amend. 85-5, before the Bureau of Eligibility, Reimbursement and Coverage, Medicaid Program, HCFA, HHS (July 24, 1986). The Respondent State of California is involved in a similar administrative hearing concerning the "first day of the month" rule application in its medically

day of the month" rule until they were told to put one into their plan in 1983. After the passage of the moratorium, it attempted to drop the rule, i.e., to apply more flexible guidelines, and was informed it could not do so because only more flexible rules in place prior to DEFRA are protected by the moratorium.

Petitioner has also used the date of DEFRA's passage as a basis for refusing to approve state plan amendments on issues other than the "first day of the month" rule. For example, rejecting the State of Michigan's proposal to apply "deeming of income and resource methodologies which differ from those methodologies in the related cash assistance programs," HCFA notes that such policies were not included in the State's "current approved plan when the moratorium became effective . . ." 51 Fed. Reg. 12646 and 12647 (April 14, 1986). In rejecting the State of Minnesota's proposed state plan amendments, relating to a number of income and resource methodologies, Petitioner, *inter alia*, maintained that the moratorium "applies only to medically needy groups and only to less restrictive provisions which were in already . . . approved State plans as of July 18, 1984 . . ." Letter of Apr. 29, 1985 from Carolyn K. Davis, HCFA Administrator to Leonard W. Levine, Commissioner, Minnesota Dept. of Public Welfare, at 2. App. A-31 to A-33. Similarly, Petitioner has denied Washington State's proposal to disregard the cost of health insurance premiums in determining medically needy eligibility, concluding that such disregards are not found in the AFDC and SSI programs, are therefore violative of § 1396a(a)(10)(C)(i)(III)

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needy program. In that action, Petitioner's Administrator at HCFA again refuses to apply the moratorium because he claims that Respondent's pre-DEFRA plan included the rule and, therefore, DEFRA would not apply under Petitioner's restrictive reading of the moratorium application period. 52 Fed. Reg. 164-165 (Jan. 2, 1987).

and are not protected by the moratorium since they are not part of an approved state plan. 52 Fed. Reg. 13133 (April 21, 1987).[21]

In short, despite the clear and broad mandate of the moratorium, Petitioner has repeatedly rejected state plan amendments that would allow greater flexibility in determining eligibility for the medically needy than is applicable to the cash assistance programs.[22] Indeed, in the instance of the "first day of the month" rule, Petitioner has rejected state plan amendments which are precisely those which the DEFRA conferees indicated should be covered by the moratorium.

Like the first day of the month rule, the conference committee also specifically addressed and permitted states to establish adult couple medically needy income levels as Respondent has done in this case. Petitioner's position that the DEFRA moratorium is not applicable to the issue before this Court should be weighed in light of his consistent refusal to apply the moratorium according to its terms and Congressional intent.

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[21] Notably, Petitioner's rejection of another Washington State plan amendment as violative of the "same methodology" requirements of § 1396a(a)(10)(C) has since been reversed by the Ninth Circuit, partially because of the protection afforded by the DEFRA moratorium. *State of Washington v. Bowen*, No. 86-7188 (9th Cir. April 20, 1987), *slip opinion* at 12 and 14. At issue was the State's proposal to use its community property law to determine ownership of income for purposes of determining Medicaid financial eligibility.

[22] *See, also* 51 Fed. Reg. 3512 (Jan. 28, 1986) (Notice of hearing to reconsider Respondent's proposals to disregard court-ordered child or financial support in considering eligibility of medically needy applicant and to apply State's community property rules in determining medically needy eligibility.)

CONCLUSION

The mandate of the DEFRA moratorium is clear. Petitioner's refusal to adhere to the moratorium in this action and in numerous other instances is equally clear. The harmful effect of Petitioner's policy on the state agencies and their medically needy applicants is without dispute. *Amici*, therefore, pray this Court to affirm the Ninth Circuit's decision with regard to the DEFRA moratorium. Finally, in the event that this Court decides contrary to Respondent in this action, it should, nevertheless, recognize and affirm Congress' intent to provide states needed flexibility in structuring and administering their Medicaid programs so as to meet the needs of their medically needy residents.

Respectfully submitted,

LACY H. THORNBURG
Attorney General of the
State of North Carolina
Department of Justice
P.O. Box 629
Raleigh, N.C. 27602-0629

HENRY T. ROSSER
Assistant Attorney General
Counsel of Record

W.J. MICHAEL CODY
Attorney General
State of Tennessee
Office of the Attorney General
450 James Robertson Parkway
Nashville, TN 37219-5025

NICHOLAS J. SPAETH
Attorney General
State of North Dakota
Bismarck, ND 58505

JEFFREY L. AMESTOY
Attorney General
State of Vermont
Pavilion Building
c/o State Office Building
State Street
Montpelier, VT 05602

HUBERT H. HUMPHREY III
Attorney General
State of Minnesota
Room 102
Capitol Building
St. Paul, MN 55155

J. JOSEPH CURRAN, JR.
Attorney General of Maryland
Munsey Building
Calvert and Fayette Streets
Baltimore, MD 21202

ROBERT M. SPIRE
Attorney General
State of Nebraska
Department of Justice
Lincoln, NE 68509

KEN EIKENBERRY
Attorney General
Office of the Attorney General
Temple of Justice
Olympia, WA 98504

Dated: Raleigh, North Carolina
July 13, 1987

APPENDIX

APPENDIX

September 22, 1982

Honorable Richard Schweiker
Secretary of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D. C. 20201

Dear Secretary Schweiker,

The State of Nebraska would like to request a waiver of the Medicaid regulations which deal with the income standards for the medically needy found in 42 CFR 435.811 (c) and 435.1007 (1) and (2). We are requesting that a waiver request of the regulation specifically for the aged, blind, and disabled group be placed on the "Governors' Fast Track".

The regulations on income standards for the medically needy in 42 CFR 435.1007 state that for FFP purposes, the income standard may not exceed 133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size.

In Nebraska, the AFDC payment standard is $210 per month for a unit size of one and increases $70 per month for each additional unit member. Therefore, the allowable medically needy standard is $283.34 per month for an individual, $375 per month for a couple, plus $75 per month for each additional individual.

If an individual or couple has income above the optional State Supplement standards, their eligibility for Medicaid must then be determined on the medically needy income standard. It has been our experience in Nebraska that the medically needy income standard allowable for FFP purposes does not adequately reflect the

needs of this group of people whether they live independently or in an alternate care facility in the community.

The maximum State Supplement standard for an individual living independently is $369 per month ($229 plus $140 maximum shelter allowance) and for a couple it is $552 per month ($377 plus $175 maximum shelter allowance). The standard for individuals living in alternate care facilities range from $329 to $384 per month depending on the type of facility in which the individual is living. Since most of these people have fixed living expenses which exceed the medically needy income standard, they are faced with a most difficult decision of meeting their basic living needs or paying for their medical needs in order to spenddown to the Medicaid standard. In the group of aged, blind, or disabled are many mentally retarded and mentally ill individuals who when faced with this choice often let their medical needs go which ultimately results in more acute medical problems at a later time.

Example #1

The following example outlines the problems experienced with those people living in alternate care facilities. In this example, the client, has $395 per month total income from Social Security. He lives in a licensed Residential Care Facility. The State Supplement standard is $379 per month. The client is allowed $30 per month for personal needs and he must pay the facility $349 for care.

$395.00	SSA
— 7.50	Unearned Income Disregard
$387.50	Net Income

$379.00	State Supplement Standard
—$387.50	Net Income
0	Budgetary need

$387.50	Net Income
—$283.43	Medical Income Standard
$104.16	Excess Income

This client is not eligible for a State Supplement, therefore, he has $104.16 per month excess income to use on medical expenses in order to spenddown to the medical standard. He still has a fixed cost of $349 to pay to the facility. This leaves him $46 per month for personal needs and medical needs. If he has a need for medication of $50 to $60 per month, it is easy to see that he cannot meet all of his expenses. This example is representative of many, many cases throughout the State.

Example #2

This example outlines the situation for an individual living independently in the community. The client is a disabled widow who receives $375 in Social Security benefits. Her prescription medications run about $200 per month. She pays $125 per month for rent.

$375.00	SSA	$229.00	Standard of Need
— 7.50	Unearned Income Disregard	+$125.00	Actual Rent
$367.50	Net Income	$354.00	Total Needs
$354.00	Total Needs	$367.50	Net Income
		−$283.34	Medical Income Standard
−$367.50	Net Income		
0	Budgetary Need	$ 84.16	Excess Income

The client is not eligible for a State Supplement, therefore, she has $84.16 per month excess income to use on medical expenses in order to spenddown to the medical income standard. The client has a fixed cost of $125 for rent and $84.16 for medical expenses which leaves her only $65.83 per month to spend for food, utilities, transportation, and other necessities of life. It is quite apparent that she cannot pay her living expenses plus her medical obligation receiving $375 SSA, which she cannot supplement by working.

One alternative to the problem would be for the State to increase the AFDC payment standard. This, however, does not seem fiscally responsible under current economic

conditions. It seems unlikely that the State Legislature would approve such an increase.

One option which we feel would help many aged, blind, and disabled individuals like those in the examples given would be to allow the State to use the State Supplement standard if it exceeds the medically needy income standard. In the case outlined in Example 1, the client's excess income would be substantially reduced:

$395.00 SSA	$387.50 Net Income
	−$379.00 State Supplement
− 7.50 Disregard	Standard
$387.50 Net Income	$ 8.50 Excess Income

In Example 2, the excess income would be eliminated:

$375.00 SSA	$354.00 State Supplement Standard
− 7.50 Disregard	−$367.50
$367.50 Net Income	0 Excess Income

The second option would be to allow the State to set the medically needy income standard for an individual based on 133⅓ percent of the AFDC payment standard for a family size of two and the medically needy income standard for a couple based on 133⅓ percent of the AFDC payment standard based on a family size of three. In 42 CFR 435.1007 (a) (2), states that the income standard for an individual may be set at 133⅓ percent of an amount *reasonably related to* the highest money payment which would ordinarily be made under the State's AFDC plan to a family size of two. We have previously received a policy interpretation from the HCFA Kansas City Regional Office that because Nebraska has an AFDC payment standard for unit size of one this reference does not apply.

Please consider our request for a waiver of the regulations in 42 CFR 435.1007 and advise us if one or both of these options is acceptable:

1. Using the State Supplement standard or the medically needy standard (see paragraph 3) to determine

medical assistance eligibility, whichever benefits the client.

2. Allow us to set the medically needy income standard for an individual based on 133⅓ percent of the AFDC payment standard for a family of two and for a couple 133⅓ percent of the AFDC payment standard for a family size of three.

The contact person for this waiver will be Donald E. Gerber, Acting State Director, Nebraska Department of Public Welfare, Box 95026, Lincoln, Nebraska 68509.

Thank you for your consideration of this matter.

With kindest regards,

Sincerely,

CHARLES THONE
Governor

CT:csg

cc: Donald E. Gerber
Acting State Director
Department of Public Welfare

bc: Margaret Hall

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201
16 May 1983

Honorable Robert Kerrey
Governor of Nebraska
Lincoln, Nebraska 68509

Dear Governor Kerrey:

This is in response to a letter of February 3, 1983 to the Secretary of Health and Human Services concerning a waiver request pertaining to 42 CFR 435.811(c) and 435.1007(a)(1) and (2) which establish the Federal financial participation (FFP) levels for Medicaid income standards applicable to the medically needy. You have requested a waiver of these provisions in order to adopt medically needy income standards for aged, blind, and disabled individuals and couples that are higher than those authorized under these provisions. You propose to use either a higher State supplement standard or an AFDC payment standard for a larger family unit than the medically needy unit.

While we appreciate the concerns raised and the reason for the request for a waiver, the regulatory provisions you have requested be waived are required by statutory limitations set forth at section 1903(f) of the Social Security Act. This section provides that FFP in expenditures for services is limited to services provided to recipients whose annual income, after certain deductions, does not exceed 133⅓ percent of the highest benefit payment that would ordinarily be made under the State's AFDC program to a family of the same size without income and resources. The statute currently provides no

authority to waive this section 1903 provision as you have requested. Accordingly, we must deny your request for a waiver of 42 CFR 435.811(c) and 435.1007(a)(1) and (2).

We cannot approve for FFP purposes use of Nebraska's current State supplement standard as the medically needy income standard since it would exceed the limit specified in section 1903(f) of the Act and in 42 CFR 435.811(c) and 435.1007. These provisions also prohibit us from approving your request to base your medically needy couple standard on the AFDC payment level for a family of three, since they provide that for FFP purposes the standard for couples cannot exceed 133⅓ percent of the amount the State's AFDC plan would pay to a family of the same size without income and resources. The statute and regulations do, however, permit for FFP purposes the medically needy standard for individuals to be up to 133⅓ percent of an amount reasonably related to the highest amount which would ordinarily be payable under the State's AFDC plan to a family of two persons without income and resources. Therefore, you may wish to submit to the regional office a State plan amendment which revises the standard for individuals.

It should also be noted that in developing medically needy income levels, section 1902(a)(10)(C)(i)(III) of the Act, as added by section 137(b)(8) of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) requires that a single standard be used for all medically needy individuals. There is no longer any provision to vary the standard by group. The exception to this provision is that a State which has exercised its option to apply criteria more restrictive than SSI may have a different medically needy income level for aged, blind and disabled, if the State had a medically needy program in effect on January 1, 1972.

We regret any inconvenience the failure to receive a response to Governor Thone's previous letter on this mat-

ter may have caused. However, as your Office was advised by the Office of the Secretary, the letter of September 22, 1982 was not received by the Department and we were not aware of the earlier request until we received the subsequent letter of February 3, 1983.

Sincerely yours,

/s/ Carolyne K. Davis
CAROLYNE K. DAVIS, Ph.D.

A-9

[Excerpts from State Medicaid Directors Report]

THE STATE MEDICAID
DIRECTORS ASSOCIATION
of the American Public Welfare Association
1125 Fifteenth Street, N.W., Washington, D.C. 20005

Suite 300
Telephone: (202) 293-7550

STATE MEDICAID DIRECTORS
REPORT TO CONGRESS ON
MEDICAID ELIGIBILITY ISSUES

Prepared by:

State Medicaid Directors Association's
Eligibility Technical Advisory Group

chaired by
Robert C. Osborne

EXECUTIVE SUMMARY

In the Deficit Reduction Act of 1984 (DEFRA), Congress directed the Secretary of Health and Human Services not to take any compliance, disallowance, or penalty against the states because states, in determining eligibility for Medicaid, were using income and resource standards or budgeting methodologies that were less restrictive than the methodologies and standards of the Aid to Families with Dependent Children (AFDC) and the Supplemental Security Income (SSI) Programs. The statute directed the Secretary to submit a report to Congress within twelve months of the enactment of DEFRA. The report must describe the impact of requiring the same budgeting methodologies of the SSI and AFDC programs on the Medicaid program.

To ensure that Congress is also made aware of the states' position, the State Medicaid Directors surveyed all states. The overwhelming conclusions indicate that the direct link between Medicaid and the cash programs results in:

—impoverishment

—increased State and Federal costs

—burdensome administrative practices.

As a result, the State Medicaid Directors are submitting this interim report to Congress which represents the states' position regarding this direct link. The report includes several examples that graphically illustrate the result of imposing these cash methodologies on states' Medicaid programs. In addition, a second states' report will offer specific alternatives to correct the deficiencies in the Medicaid eligibility process.

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[Page 6]

One-Third Reduction

In the SSI program, recipients residing in the household of another have their Federal SSI benefit rate reduced by one-third. This same policy applied in the Medicaid program would require that the income eligibility standard be reduced by one-third for persons living in the household of another.

> In another hypothetical example, Mr. R, who is a Medicaid recipient in the State of Minnesota, resides with his son and daughter-in-law. This policy would have the following effect on his application for Medicaid. He receives net income of $300 a month. The monthly medically needy income standard in Minnesota is $347. Since Mr. R is residing with his family, the state's medically needy income standard for him would be two-thirds of $347 or approximately $233 per month. In order for Mr. R to be eligible for Medicaid, he must incur medical expenses equal to the difference between his income, $300, and the two-thirds standard, $233 per month. Therefore, he has to incur medical expenses in the amount of $67 per month before he is eligible for Medicaid. This ⅓ reduction policy appears to be in conflict with the requirements at Section 1902(a)(10) of the Social Security Act, relating to a "single income standard'.

POLICY CONFLICT WITH OBRA

OBRA promulgated policies intended to encourage the utilization of long term home health care as an alternative to having the frail elderly institutionalized in a long term care facility (i.e., nursing home). Requiring states to consider the value of the in-kind income or the one-third reduction serves as a disincentive for families and friends willing to bring the frail elderly into their homes since in many instances the value of the in-kind income or the

one-third reduction decreases the elderly person's monthly cash by requiring them to incur medical expenses before becoming fully eligible for Medicaid. The cash SSI policy and the purposes and intent of the Medicaid program are clearly incompatible in these areas.

[Page 7]

IV. QUESTIONNAIRE AND RESULTS

In order to collect data necessary to complete its report to Congress, HCFA requested assistance from the Eligibility—Technical Advisory Group (E-TAG), an advisory group comprised of Medicaid eligibility experts from ten states. The E-TAG collected information on the effects of some of the cash policies on Medicaid applicants and recipients. States were asked to complete a questionnaire consisting of nine current cash assistance policies which states are finding difficult to apply in the Medicaid program, as required by HCFA. The questionnaire also contained nine alternative policy provisions upon which states were asked to comment. (The alternative policies will be explained in the states' final report to Congress.) (Responses were received from thirty-nine states.* Although all states did not respond, the variance in the size of those states replying indicates that the results are representative of the nation as a whole. The table and charts on pages 11 through 13 illustrate some of the results of the questionnaire. Findings in relation to other policy conflicts are included in the addendum.

12:01 AM Resource Policy

As depicted in the table on page 11, 76.9% of the states responding indicate that the current Federal policy of denying Medicaid eligibility for the entire month if there are excess resources as of 12:01 AM on the first day of

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* Completed questionnaires were received from 35 states. Telephone responses were received from 4 other states.

the month is detrimental to the client population. Only 2.6% of the responses indicate that the current policy is helpful.

In addition to the adverse effect on clients, 38.5% of the states responding indicate that this policy is detrimental to state administration of the Medicaid program. While 35.9% of the states report that this policy has no effect, only 20.5% of the respondents reported that this Federal policy is helpful to state administration of the Medicaid program.

In-Kind Income/One-Third Reduction

These two policies are basically very similar. They are both based on the provision of certain needs without cost and relate to income which is not physically available to the client.

[Page 8]

As shown in the table on page 11, 79.5% of the states responding to this issue stated that the current Federal policy on in-kind income is detrimental to the client population and no state indicated that the current Federal policy is helpful to the client population.

In addition, 71.8% of the respondents indicate that the current Federal policy is cost detrimental to administration of the Medicaid program. (Administrative costs are shared by the Federal and State governments.) Conversely, only 2.6% feel that the current policy is helpful.

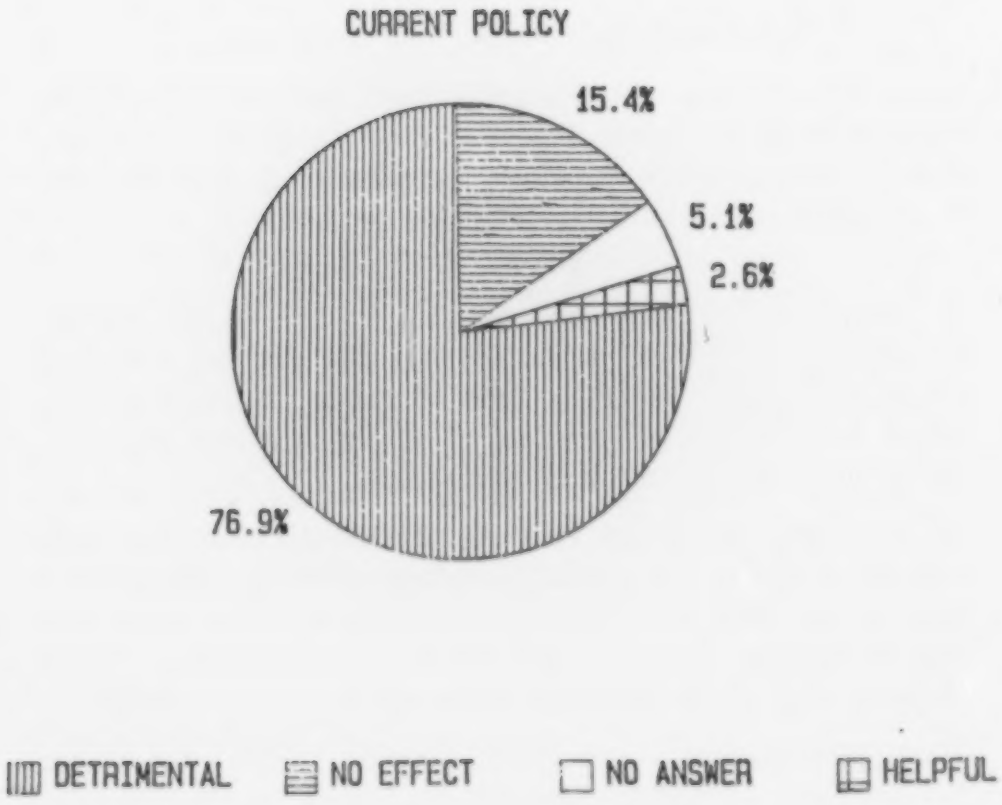
This policy makes it extremely difficult, if not impossible, for the frail elderly to maintain residence in the community. Greater institutionalization, in turn, results in higher Medicaid costs for both the State and Federal governments since institutional care is generally much more expensive than community-based care.

* * * *

[Page 12]

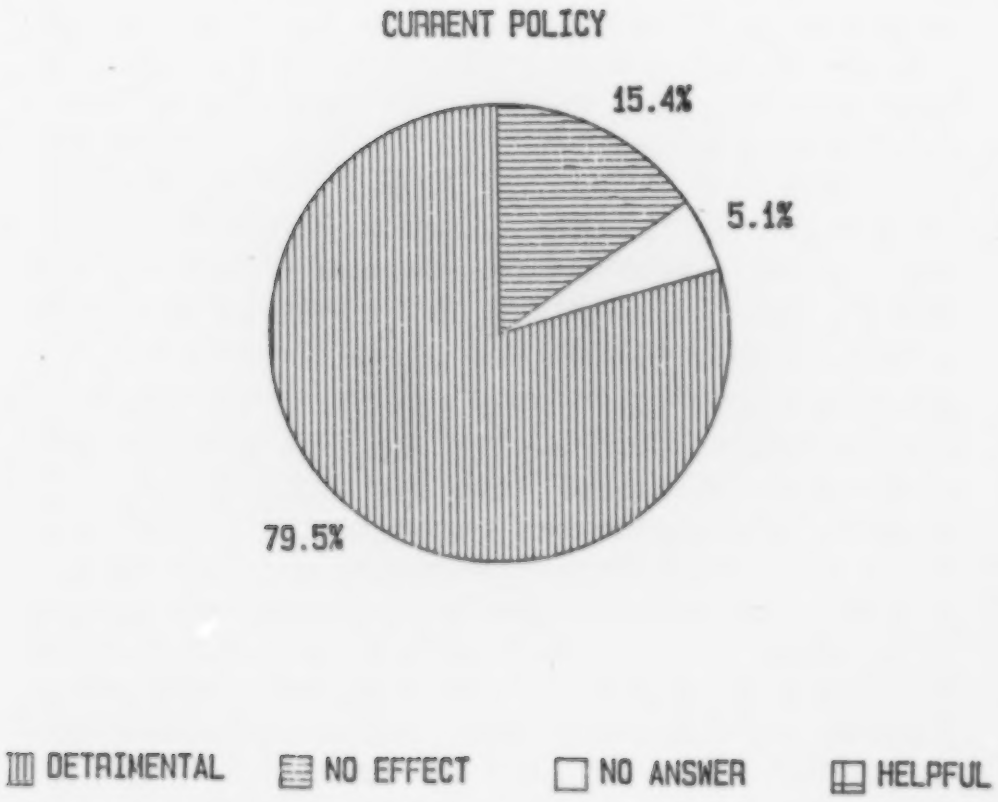
12:01 A.M. RESOURCE POLICY

EFFECT ON CLIENT POPULATION



INKIND INCOME

EFFECT ON CLIENT POPULATION



[Addendum A and portion of Addendum B to State Medicaid Directors Report]

ADDENDUM

Responses to the questionnaires from the states on other policy issues serve to further illustrate the inconsistencies between the cash assistance programs and the Medicaid program.

Date Specific Eligibility

In both the SSI and the AFDC programs, eligibility is established as of a specific day in the month. In the SSI program, the effective date is the date the application is filed; in AFDC, it is the date that the family is determined eligible to receive a grant. In both situations, the initial cash grant is pro-rated to cover the days from the effective date of eligibility through the end of the month. Medicaid has always had the option of establishing the effective date of eligibility as the first day of the month in which an application is filed.

Again, the differences in the purposes of the Medicaid program and the cash programs should be obvious. Cash programs are designed to meet basic maintenance costs. A person applying for cash assistance at some point in a month has managed some how prior to that date. In this situation, date specific eligibility is a viable cost savings methodology. On the other hand, persons and families marginally able to keep up with those basic maintenance expenses would be totally devastated by unexpected medical expenses. The application for Medicaid is often triggered by such costs, and is generally made at a point in time after the expense was incurred.

The following hypothetical example illustrates this point. Mr. and Mrs. H and their two children are just managing to make ends meet on his net unemployment insurance of $487 per month. One of the children is rushed to the hospital on June 3 for an emergency appendectomy. Realiz-

ing that they no longer have health insurance since Mr. H was laid off, they file for Medicaid on June 8 as soon as the child is out of the hospital. On June 15 they are determined eligible for Medicaid effective on that date. However, coverage is not available for the period from June 3 to June 8, since eligibility had not yet been established, and the H's are faced with a hospital bill of $3,000 which they have no means to pay.

Under section 1902(a)34 of the Social Security Act, states must provide Medicaid for a period of not more than three months prior to the month of application if the person was eligible in that period. Thus, the H family may be eligible for Medicaid in March, April and May under the retroactive provisions of the Medicaid program, but would not be eligible in the beginning of June because the states must impose the "date specific eligibility policy" of the AFDC program.

Of the 39 states responding to this policy area, 66.7% felt that requiring date specific eligibility was detrimental to the interests of the client, and 77% felt that establishing eligibility as of the first of the month either has no administrative effect, or is administratively easier for a state agency.

* * * *

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date Jun. 3, 1985

From Director
Bureau of Eligibility, Reimbursement and Coverage

Subject Medicaid Eligibility—Status of SSI Resource Policy Relating to "Bona Fide Effort to Sell"—POLICY INFORMATION FOR ALL REGIONS AND STATES EM 6-85-1

To Regional Administrators
Regions I-X
Attn: Policy and Technical Assistance Branch
Division of Program Operations

The following item concerns a recent development in SSI policy which affects Medicaid eligibility.

SSI instructions relating to "bona fide effort to sell" contained in the Social Security Administration (SSA) Program Operations Manual System (POMS) at SI 01130.330 appear to permit a blanket exclusion for an asset that is not salable at the asking price or original current market value. To the extent the instruction would authorize this treatment of resources, the POMS provision is not a correct reflection of SSI resource policy. SSI resource policy on this subject is reflected in Social Security Administration Ruling (SSR 83-30a) under which there is no "bona fide effort to sell" policy in SSI that would create such a blanket exclusion of resources. As such, any State policy which extends Medicaid eligibility on the basis of a "bona effort to sell" policy which provides for a blanket exclusion from resources of an asset which is not salable at the asking price or original current market value would be more liberal than SSI policy.

In other words, Medicaid eligibility can no longer be extended to individuals who have excess resources and who are making a bona fide effort to sell. Medicaid eligibility based on "bona fide effort to sell" does not exist. Individuals who have excess resources are ineligible for Medicaid.

In general, section 1902(a)(10)(A) of the Act applicable to the categorically needy and section 1902(a)(10)(C) applicable to the medically needy do not permit States to apply eligibility criteria more liberal than the eligibility criteria applied under the SSI program. Additionally, section 1902(f) and 42 C.F.R. 435.121 (which relates only to 209(b) States) permits States to be more restrictive but not more liberal than SSI.

As this represents a clarification of policy, States which require a change in policy must implement such a change by the first day of the month following the 30th day from the date of the memorandum.

/s/ Henry R. Desmarais
HENRY R. DESMARAIS, M.D.

MEDICAID
Action Transmittal

Department of Health and Human Services
Health Care Financing Administration

Transmittal No. 85-1

Date January 1985

TO:

STATE AGENCIES ADMINISTERING MEDICAL ASSISTANCE PROGRAMS

SUBJECT:

HCFA's Interpretation of the Medicaid Moratorium Provisions of Section 2373(c) of the Deficit Reduction Act

STATUTORY REFERENCES:

Section 2373(c) of Public Law 98-369 (the Deficit Reduction Act of 1984) and Section 1902(a)(10)(C)(i)(III) of the Social Security Act.

ATTACHMENTS:

Text of Section 2373(c) of Public Law 98-369.

PURPOSE:

The purpose of this transmittal is to inform Medicaid State Agencies of the provisions of Section 2373(c) of the Deficit Reduction Act of 1984 (DRA) and to provide instructions on HCFA's interpretation of its implementation.

BACKGROUND:

Prior to the Omnibus Budget Reconciliation Act of 1981 (OBRA), States were required to follow the methodologies and standards used in the cash assistance programs for determining the financial eligibil-

ity for both the categorically needy and the medically needy with certain specified exceptions. With the enactment of the OBRA (P.L. 97-35), the Medicaid statute of section 1902(a)(10)(C) of the Social Security Act (the Act), as implemented by regulations which were effective on October 1, 1981, permitted States in determining eligibility of medically needy individuals to apply methodologies that could differ from those used in the relevant cash assistance program where the Secretary determined them to be reasonable. Thus, States were permitted to use methodologies which were more or less restrictive than the Aid to Families with Dependent Children or Supplemental Security Income eligibility methodologies in determining eligibility of their medically needy. Under the OBRA provisions, States were required to submit amendments to their title XIX State plans where they wished to apply Medicaid requirements that differed from those of the cash assistance programs.

With the enactment of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) on September 3, 1982, the Medicaid statute at section 1902(a)(10)(C) of the Act was again amended. These amendments were effective retroactively to the effective date of the OBRA changes. Under the TEFRA (P.L. 97-248) provisions, in determining eligibility of medically needy individuals, States were required to use the same methodologies as those used in the cash assistance programs. Thus, subsequent to TEFRA, any State Medicaid plan submitted which contained different (for example, less restrictive) methodologies than those used in the cash assistance programs should have been disapproved. Additionally, where States were using less restrictive methodologies or standards, compliance proceedings or disallowance could have been initiated.

On July 18, 1984 the DRA was enacted. Section 2373(c) of DRA contained provisions which imposed a moratorium on certain HHS actions arising from States' use of certain standards or methodologies in their medically needy programs. See below for a discussion of these provisions of the DRA.

PROVISIONS OF SECTION 2373(c) OF DRA:

Section 1902(a)(10)(C)(i)(III) of the Act requires that in determining Medicaid eligibility States must apply the same income and resource methodologies as are used in the cash assistance programs and utilize a single income and resource standard. Under section 2373(c) of the DRA the Secretary is prohibited from taking any sanctions (such as compliance, disallowances, penalties, or other regulatory action) against States during a specified moratorium period (see following section on moratorium period) where the States' approved Medicaid plans contain less restrictive income or resource methodologies or standards than would otherwise be prohibited under section 1902(a)(10)(C)(i)(III). The moratorium on these sanctions applies only where the existing approved State plan is or would be in violation of the provisions of section 1902(a)(10)(C)(i)(III) of the Act by reason of the application in the Medicaid program of less restrictive income or resource methodologies or standards than are required under that section of the Act.

MORATORIUM PERIOD:

The moratorium period extends from the date of enactment of the DRA (July 18, 1984) until 18 months after the date on which the Secretary submits a report to Congress with respect to the application of less restrictive cash assistance program in-

come or resource methodologies and standards in the Medicaid program. This report is to be submitted to Congress within 12 months from the date of enactment of the DRA. States will be informed of the specific termination date of the moratorium period following the submittal of the report.

IMPLEMENTATION OF THE MORATORIUM PROVISIONS:

During the moratorium period referred to above, compliance, disallowance, or other regulatory actions will not be taken against a State by HCFA, but only with respect to less restrictive provisions covered by the moratorium and contained in the State's existing approved Medicaid plan. Furthermore, the Medicaid statute at section 1902(a)(10)(C)(i)(III) of the Act was not revised by the DRA. Therefore, subsequent to the DRA, any pending or new submitted State plan amendments, which contain less restrictive provisions which are still prohibited under section 1902(a)(10)(C) of the Social Security Act, will not be approved.

The less restrictive methodologies or standards permitted under the moratorium may apply only to individuals covered under section 1902(a)(10)(C) of the Act (i.e., the medically needy). Thus, the less restrictive provisions covered under the moratorium do not apply to categorically needy individuals covered under section 1902(a)(10)(A) of the Act.

LESS RESTRICTIVE METHODOLOGIES AND STANDARDS:

Section 2373(c) refers to those less restrictive methodologies or standards covered by section 1902(a)(10)(C)(i)(III) of the Act. Section 1902(a)(10)(C)(i)(III) of the Act refers to those methodologies and standards used in determining income and re-

source eligibility for medically needy applicants or recipients. Furthermore, the methodologies are those related to the appropriate cash assistance programs. Therefore, only those less restrictive methodologies and standards which have the following characteristics will be permitted under the moratorium:

1. They are used in determining eligibility for the medically needy.

2. They must only be income or resource methodologies and standards. Other types of nonfinancial methodologies or standards are not covered. Thus, for example, a State could not apply more liberal definitions of disability, age, or blindness than used in the SSI program.

3. The methodologies must be less restrictive with respect to a methodology of the cash assistance programs. Thus, a State could not be more liberal in its spend down program in respects which do not have counterparts in cash assistance program eligibility methodologies. For example, a State could not consider, for purposes of spend down, as "incurred expenses for medical care" expenses which would not be recognized as being for medical care.

4. The less restrictive provisions must not violate other sections of Medicaid statute. For example, section 1903(f)(1) of the Act provides Medicaid requirements for Federal financial participation, requiring a limitation on matching related to medically needy individuals' income. Any less restrictive requirements which violate other Medicaid provisions would also not be approvable.

HCFA will determine whether a particular methodology or standard is less restrictive and is otherwise covered within the purview of the moratorium provisions.

STATE PLAN APPROVAL PROCESS:

Only those less restrictive provisions already in existing approved State plans as of the date of enactment of the DRA (July 18, 1984) will be permitted under the moratorium. No sanctions such as compliance actions will be taken against States with respect to these less restrictive provisions covered by the moratorium and contained in already approved Medicaid State plan preprint pages.

States whose preprint contains pages covering provisions covered by the moratorium may wish to revise their Medicaid plan in the future. HCFA does not interpret the moratorium to require us to prospectively approve new plan amendments which in any respect violate the requirements of section 1902 (a) (10) (C) (i) (III) of the Act. If a State wishes to preserve provisions in its State plan which are protected by the moratorium while it is amending other material on a preprint page which contains material protected by the moratorium, it should indicate that it is only seeking approval of the new material and that it wishes to preserve the original approval dates of the provision which are protected by the moratorium. It should retain in its plan (even after the new material is approved), the original preprint pages which were approved and which are protected by the moratorium. These pages should should be appended to the newly approved pages.

IMPACT ON MEDICAID ELIGIBILITY QUALITY CONTROL:

Since the moratorium applies only where the existing approved State plan is or would be in violation of the provisions of section 1902(a) (10) (C) (i) (III) and since Medicaid eligibility quality control

(MEQC) reviews are conducted against the approved State plan, the moratorium will have no effect on MEQC reviews or error rates for past or future periods.

INQUIRIES TO:

Regional Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing
Administration

Region IV
101 Marietta Tower
Atlanta GA 30323

March 28, 1983

Ms. Barbara Matula, Director
Division of Medical Assistance
410 North Boylan Avenue
Raleigh, North Carolina 27603

Dear Ms. Matula:

We have received your letter, dated February 4, 1983, which outlines the State's review procedures for cases found ineligible due to bank accounts/assets with excess reserve. The information you received on this issue and the information contained in your letter is incorrect.

According to a change in SSI policy, effective April 1, 1982, the amount of a recipient's resources as of the first moment of the first day of the month will be counted for the entire month. The phrase, "resources as of the first moment of the first day of the month," means existing resources on the first day of the month before any additions or deletions have taken place. The State is to follow this policy according to Health Care Financing Administration Transmittal Notice #16-82, dated March 18, 1982, which states, "This SSI resource policy must be used in determining Medicaid eligibility for categorically needy individuals in States which cover all SSI recipients and in 209(B) States if the State's current policy, or policy in effect on January 1, 1972 is more liberal than SSI policy." This policy also applies to medically needy individuals since there is no provision for spending down resources.

Quality Control reviewers should apply the above policy by verifying resources as of the first moment of the first day of the review month and of the prior month. If the amount of the resources exceeds the maximum allowable resources on both days, the case is in error.

If you have any questions, please contact Charles Sessums at (404) 221-2441.

Sincerely yours,

/s/ James J. Pirkle
JAMES J. PIRKLE
Associate Regional Administrator
Division of Financial Operations

DEPARTMENT OF HEALTH & HUMAN SERVICES

The Administrator
Washington, D.C. 20201

Oct. 25, 1985

Mr. Phillip J. Kirk, Jr.
Secretary
North Carolina Department of Human Resources
325 North Salisbury Street
Raleigh, North Carolina 27611

Dear Mr. Kirk:

We have reviewed North Carolina's Medicaid State Plan Amendment (SPA) No. 85-5 and are unable to approve the proposed changes with respect to allowing medically needy individuals to become eligible on the day countable resources are reduced to the allowable resource amount.

Under Federal statute at section 1902(f) of the Social Security Act and implementing regulations at 42 CFR 435.121, States such as North Carolina must use Medicaid eligibility criteria for the aged, blind and disabled, which are no more restrictive than those contained in the State's January 1, 1972 Medicaid State plan, and no more liberal than the requirements of the Supplemental Security Income (SSI) or an optional State supplement program.

Under the SSI program an individual's resources are accounted for as of the first moment of the first day in a month (SSI Program Operations Manual System Section SI 01150.005). If at that point the individual's countable resources are less than or equal to the allowable resource limit, the individual is resource eligible. If, however, the countable resources exceed the resource level, the individual is ineligible and remains so for the rest of the month, regardless of whether the resources are

reduced below the resource level subsequently during the month.

Under SPA 85-5 North Carolina would permit medically needy aged, blind, and disabled individuals with excess countable resources as of the first moment of the first day in the month to become eligible if, during the month, the resources are reduced to the resource limit. Thus, North Carolina under SPA 85-5 would apply a more liberal rule than permitted under the Medicaid statute and regulations cited above.

This proposed SPA is not affected by the moratorium on compliance, disallowance, penalty or other regulatory actions established by section 2373(c) of the Deficit Reduction Act of 1984 (DEFRA). The moratorium permits States to continue to apply more liberal financial eligibility rules than SSI but only with respect to provisions already contained in a State's Medical State Plan as of the enactment of DEFRA on July 18, 1984. As of that date, North Carolina's State plan did not contain a provision such as contained in SPA 85-5.

Based on the above and after consultation with the Secretary as required by 45 CFR 201.3, I am hereby disapproving the subject plan amendment because it is in violation of existing Federal law and regulations. If you are dissatisfied with this determination you may petition for reconsideration of the issue within 60 days after the date of this letter in accordance with the procedure set forth in 45 CFR 201.4.

If you wish to discuss the implications of this disapproval further please contact Mr. Richard L. Morris, Associate Regional Administrator, Suite 701, 101 Marietta Tower, Atlanta, Georgia 30323.

Sincerely yours,

/s/ C. McClain Haddow
C. McCLAIN HADDOW
Acting Administrator

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration
The Administrator
Washington, D.C. 20201

Apr. 29, 1985

Mr. Leonard W. Levine
Commissioner
Minnesota Department of Public Welfare
Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Dear Mr. Levine:

The Health Care Financing Administration has carefully reviewed your proposed title XIX State Plan Amendments (Transmittal Numbers 83-30 and 83-35). These plan amendments provide for a number of financial (income and resource) methodologies to be applied under the Minnesota Medicaid program.

Both plan amendments contain disapprovable provisions which are summarized below and described in greater detail in the attached report. Furthermore, both plan amendments contain approvable portions which are also discussed in the enclosed report.

Generally, the Medicaid statute at section 1902(a)(10)(A) and (C) of the Social Security Act (the Act) requires States to apply the same financial methodologies as are applied in the cash assistance programs (for example, SSI or AFDC) in determining eligibility for Medicaid in their medically needy programs. Under SPAs 83-30 and 83-35 Minnesota proposes to apply a number of income and resource methodologies which are more liberal than the related cash assistance programs. Thus, these amend-

ments violate section 1902(a)(10)(C) of the Act and must be disapproved on that basis.

Section 1902(f) of the Act does permit States, such as Minnesota, to apply financial methodologies which are more restrictive than the methodologies of the cash assistance programs but no more restrictive than those contained in the State's January 1, 1972 Medicaid State plan. Note, under section 1902(f) of the Act a State may not apply methodologies which are more liberal than the cash assistance programs. Under SPAs 83-30 and 83-35 Minnesota proposes to apply a number of income and resource methodologies which are more restrictive than those contained in its January 1, 1972 plan. Thus, these amendments must be disapproved on that basis.

Additionally, section 1902(a)(17) of the Act as implemented in regulations at 42 CFR 435.831 and 435.832 requires States to use a two-step process in determining first, medically needy eligibility and second, post-eligibility application of income to the cost of care for institutionalized individuals. These steps are separate and different. Under SPA 83-30 Minnesota proposes to apply a single step for determining both eligibility and post-eligibility treatment of income for institutionalized individuals Thus, SPA 83-30 violates regulations at 42 CFR 435.831 and 435.832 and must be disapproved on that basis. Furthermore, section 1902(a)(1)(C)(i)(III) of the Act requires that Medicaid eligibility for the medically needy must be determined by the use of a single income standard which can vary as provided by section 1902(a)(17), only with respect to differences in shelter costs between rural and urban areas. Therefore, the single standard cannot vary based on living arrangements, i.e., on institutionalization versus residing in the community. The Minnestota proposal effectively imposes a medically needy income eligibility standard for institutionalized individuals which is different from the medical needy income level used to determine eligibility of individuals residing

in the community. The eligibility standard proposed for institutionalized individuals is derived from the State's institutional payment rate.

You believe the income and resource methodologies proposed in SPAs 83-30 and 83-35 are allowable under section 2373(c) of the Deficit Reduction Act of 1984 (DEFRA). Section 2373(c) of DEFRA imposed a "moratorium" with respect to the application of the provisions of the law requiring the cash assistance methodologies to be applied under medically needy programs. Under the moratorium, less restrictive financial eligibility methodologies may be applied to provisions in the State plan. However, the moratorium applies only to medically needy groups and only to those less restrictive provisions which were in already contained approved State plans as of July 18, 1984, the effective date of DEFRA. Since the proposals contained in Minnesota SPas 83-30 and 83-35 are either not already contained in your currently approved State plan or apply to categorically needy groups, these provisions are not covered by the moratorium. Thus, the moratorium provisions do not apply to Minnesota SPAs 83-30 and 83-35.

Based on the above and after consultation with the Secretary as required by 45 CFR 201.3, I am hereby disapproving those disapprovable provisions of SPA 83-30 as discussed in the attached report and Supplement 2 to Attachment 2.6-A page 2 of SPA 83-35. These provisions of SPA 83-30 and 83-35 are in violation of existing Federal law and regulations. If you are dissatisfied with this determination, you may petition for reconsideration of the issue within 60 days after the date of receipt of this letter in accordance with the procedure set forth in 45 CFR 201.4.

Sincerely yours,

/s/ Carolyne K. Davis
CAROLYNE K. DAVIS, Ph.D.

Enclosure